

CERTIFICATE OF DEATH

Reg. Dist. No. 07173

7184

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island				c. LENGTH OF STAY in 1b lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marguerite Middle Coster Last Coster				4. DATE OF DEATH Month June Day 18 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1892		9. AGE (In years last birthday) yrs. 68	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household		10b. KIND OF BUSINESS OR INDUSTRY Household		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore White				14. MOTHER'S MAIDEN NAME Jennie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO.		17. INFORMANT George Coster		Address Deal Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from July 1955 , 19____, to June 18 , 19 61 , that I last saw the deceased alive on 6-13-61 , 19____, and that death occurred at 8AM M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Everett C. Sutter				ADDRESS (Street, city or town, state) Dames Quarter, Maryland			
DATE SIGNED 6-19-61							
PHYSICIAN'S NAME (Type) Everett C. Sutter MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/61		22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR JUN 27 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate is to be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07175

1. PLACE OF DEATH e. COUNTY Somerset MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b None d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 518 Young Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia First Middle Last Cropper		4. DATE OF DEATH Month Day Year June 30 1961	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 24, 1896 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser 10b. KIND OF BUSINESS OR INDUSTRY Beauty Parlor		11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Giller		14. MOTHER'S MAIDEN NAME Rachel Savage	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Janie Thomas Address Atlantic, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Had previous history of treatment, coronary condition, by Dr. Norman Sartorius, Sr., Pocomoke City, Md.) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/1/61	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-61	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery		22d. LOCATION (City, town, or country) (State) Temperanceville Va.	
23. FUNERAL DIRECTOR Wharton & Savage		24a. REC'D BY REGISTRAR DATE JUL 7 '61	
ADDRESS New Church, Va.		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

(M)

(I)

Robert

William

Robert

John

Robert

Robert

Robert

Robert

Robert

Robert

Robert

Robert

Robert

X

X

X

X

Robert

Robert

Robert

Robert

Robert

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7186

CERTIFICATE OF DEATH

Reg. Dist. No. 07175

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>				c. LENGTH OF STAY IN 1b <u>2 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leoden</u> Middle <u>Doane</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Finishing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>							
13. FATHER'S NAME <u>Samuel Henry Doane</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>716-01-7158</u>		17. INFORMANT <u>Marion Cannon, Eden, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ree Older Carcinomatosis involving Sarcoma Left Shoulder.</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic Ca of Lungs.</u> DUE TO (c) <u>Skin Involvement</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Feb. 13, 1961</u> to <u>June 9, 1961</u> , that I last saw the deceased alive on <u>June 9, 1961</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sempley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury, Md.</u>		DATE SIGNED <u>6/23/61</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sempley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>				ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR <u>DATE UN 26 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7187

CERTIFICATE OF DEATH

Reg. Dist. No. 07176

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne, X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Alice Elizabeth Jackson</u>		4. DATE OF DEATH <u>June 15 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmond Brockett</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Brockett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>159-34-3594</u>	
17. INFORMANT <u>Joseph Brockett</u>		Address <u>Princess Anne, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>Cardiac Decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs.</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1959</u> to <u>June 15 1961</u> , that I last saw the deceased alive on <u>June 15 1961</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.		ADDRESS (Street, city or town, state) <u>20 Prince William St Princess Anne</u>	
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI M.D.</u>		DATE SIGNED <u>6/16/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 18, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>	22d. LOCATION (City, town, or county) (State) <u>Greenwood Som. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H Ward</u>		ADDRESS <u>Marion Md</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUN 19 61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM A. JONES

NAME OF DECEASED		WILLIAM A. JONES	
AGE		60	
SEX		M	
RACE		W	
DATE OF DEATH		JAN 15 1950	
PLACE OF DEATH		HOME	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MD	
CAUSE OF DEATH		CORONARY THROMBOSIS	
MANNER OF DEATH		NATURAL	
OCCUPATION		CLERK	
EDUCATION		HIGH SCHOOL	
RELIGION		METHODIST	
MARRIAGE		MARRIED	
SPOUSE		JANE JONES	
CHILDREN		JOHN JONES, DAUGHTER	
SIBLINGS		NONE	
PARENTS		JOHN JONES, FATHER	
MOTHER		MARY JONES	
BIRTH DATE		JAN 15 1890	
BIRTH PLACE		BALTIMORE, MD	
BIRTH STATE		MD	
BIRTH COUNTRY		USA	
BIRTH CITIZENSHIP		NATURALIZED	
BIRTH RACE		W	
BIRTH SEX		M	
BIRTH AGE		60	
BIRTH PLACE		BALTIMORE, MD	
BIRTH STATE		MD	
BIRTH COUNTRY		USA	
BIRTH CITIZENSHIP		NATURALIZED	
BIRTH RACE		W	
BIRTH SEX		M	
BIRTH AGE		60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed and signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07177

7188

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Rufus Middle J. Last Miles				4. DATE OF DEATH Month June Day 14 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1869		9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John L. Miles			
14. MOTHER'S MAIDEN NAME Malcah Muir Lansing				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Miss Margaret Miles Upper Fairmount, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) PRIMARY CARCINOMA LIVER (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 4 MONS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/9 , 19 58 , to 6/14 , 19 61 , that I last saw the deceased alive on 6/14 , 19 61 , and that death occurred at 10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) 212 MARKET ST.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON POCOMOKE CITY, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-17-1961		22c. NAME OF CEMETERY OR CREMATORY Miles Cemetery		22d. LOCATION (City, town, or county) (State) Upper Fairmount, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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FOR STATE
HEALTH DEPT
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19
2
TO NOTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7189
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7189
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07178

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 125 Maple St.			d. STREET ADDRESS 125 Maple St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT MILBURN REVELLE			4. DATE OF DEATH Month Day Year June 3 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1937		9. AGE (In years last birthday) 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Pleasure Boat Mfg.		11. BIRTHPLACE (State or foreign country) Crisfield, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME R. Milbourn Revelle			14. MOTHER'S MAIDEN NAME Florence Marie Davis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1957 (6 Mos.)			16. SOCIAL SECURITY NO. 219-34-3964		
17. INFORMANT Mrs. Florence Marie Milbourn--			Address 125 Maple St. Crisfield, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage (brain stem) due to blow on head with baseball. 910.4 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck in forehead by baseball from foul tip			
20c. TIME OF INJURY Month, Day, Year Hour Minute p.m. 3:00 June 2 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Recreation area	
20f. (City or town) Crisfield		20g. (County) Somerset		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE C. G. Rawley			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) C. G. Rawley, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED 6/5/61		
			Address (Street, city, town, or county) Crisfield, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1961		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	
				22d. LOCATION (City, town, or county) Crisfield, Md.	
23. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.			24a. REC'D BY REGISTRAR JUN 9 '61		
			24b. REGISTRAR'S SIGNATURE Wm. L. P. P.		

UNITED STATES

1917

(M)

(I)

1917

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1917

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1917

CERTIFICATE OF DEATH

Reg. Dist. No. 07179

7190

M

1. PLACE OF DEATH
a. COUNTY

SOMERSET

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

MARYLAND

b. COUNTY

SOMERSET

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CRISFIELD

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

39 CRISFIELD

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

EDW. W. MCCREADY MEMO. HOSP.

d. STREET ADDRESS

1 143 S. FOURTH STREET

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐3. NAME OF DECEASED
(Type or print)

First

CLYDE

Middle

R

Last

SAMPLE

4. DATE OF DEATH

Month

JUNE

Day

7

Year

1961

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-14-1888

9. AGE (In years last birthday) yrs.

73

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN A. SAMPLE

14. MOTHER'S MAIDEN NAME

ANNIE BIVENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-01-9049A

INFORMANT

Address

SALLY A. SAMPLE, CRISFIELD, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

(c)

Acute dilatation, heart -
Coronary occlusion -
Aortic arteriosclerosis -

INTERVAL BETWEEN ONSET AND DEATH

10 days

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19____, to 6-7-61, 19____, that I last saw the deceased alive on 6-7-61, 19____, and that death occurred at 10:35 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

C. G. Rawley

M.D.

CRISFIELD, MARYLAND

PHYSICIAN'S NAME (Type)

C. G. RAWLEY, M. D.,

CRISFIELD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

June 11, 1961

22c. NAME OF CEMETERY OR CREMATORY

Hickory

22d. LOCATION (City, town, or county)

CRISFIELD

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Anthony E. Wood 114 S. 4th St. Crisfield, Md.

24a. REC'D BY REGISTRAR

DATE JUN 12 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Hanna

STATE OF NEW YORK
IN SENATE
January 12, 1909.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1908.
ALBANY:
J. B. LEECH, STATE PRINTER.
1909.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07180

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Granville Sanders		4. DATE OF DEATH Month Day Year June 12 19 61	
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1877
9a. AGE (In years last birthday) 83 yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Sanders		14. MOTHER'S MAIDEN NAME Esther Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Amanda Sanders, RFD. Princess Anne			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 months years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-2-59, 19, to 6-12-61, 19, that I last saw the deceased alive on 6-12-61, 19, and that death occurred at 10AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dames Quarter, Md. DATE SIGNED 6-13-61 ACTUAL SIGNATURE Everett C. Sutter M.D. PHYSICIAN'S NAME (Type) Everett C. Sutter MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/14/61	22c. NAME OF CEMETERY OR CREMATORY St Andrews	22d. LOCATION (City, town, or county) (State) Princess Anne Md
23. FUNERAL DIRECTOR'S SIGNATURE James L. Hanna ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

7192

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07181

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime 39 Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Somerset Ave.		d. STREET ADDRESS S. Somerset Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle JAMES Last WARD		4. DATE OF DEATH Month June Day 20 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1883
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ward		14. MOTHER'S MAIDEN NAME Eliza Cullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 218-05-8809	
17. INFORMANT Mrs. Lena Ward, S. Somerset Ave., Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to June 20, 1961 , that (I) (we) last saw the deceased alive on 6-19 19 61 , and that death occurred at 2:15 M, from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.		22d. ADDRESS W. Main St., Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		25a. REC'D BY REGISTRAR DATE JUN 23 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

Reg. Dist. No. 07182

7193

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>WHEATLEY</u> Last <u>WHEATLEY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-28-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GABRIEL JONES</u>		14. MOTHER'S MAIDEN NAME <u>TRISCILLA WHITE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARTIN WHEATLEY</u>		Address <u>DEAL ISLAND MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioneophrosis of kidneys</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis heart disease</u> DUE TO (c) <u>arteriosclerosis heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH years <u>1</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-26-61</u> , 19 <u>61</u> , to <u>6-5-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-5-61</u> , 19 <u>61</u> , and that death occurred at <u>8pm</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Everett C. Sutter</u>		ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>		DATE SIGNED <u>6-5-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 7-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>Chance MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Webster</u>		ADDRESS <u>Princess Anne</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>John S. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

